Aspirus Network, Inc. (ANI)
Practice Demographic or Location Change Form

If your practice is changing any practice demographic or location information that has been previously reported to ANI (i.e., Taxpayer Identification Number (TIN), National Provider Identifier (NPI), address, demographic information, legal name, dba name, etc.), please complete this Practice Demographic or Location Change Form in its entirety and submit to ANI's Customer Service at Customerservice-ANI@aspirus.org.
For awareness:

- Changes to a taxpayer identification number (TIN), legal name or "Doing Business As" (DBA) name, NPI, or credentialed/licensed facility, can result in additional ANI payor contracting requirements, including *potentially facility re-credentialing and/or an ANI payor contract amendment.* To that end, prior to contacting ANI Customer Service about the change, please reach out to ANI's contracted payors directly to check if the change will require re-credentialing of your practice's facility. A contact list for ANI's contracted payors is available on ANI's website in the Contracted Payor Information section.

  If re-credentialing or an ANI payor contract amendment is required, the process can take up to one hundred and eighty (180) days to complete. As such, please allow sufficient planning time. This Form should be submitted to ANI's Customer Service at least one hundred and eighty (180) days in advance of the desired effective date.

- For a practice demographic or location change that does not impact licensed or credentialed facilities, please submit this completed Form to ANI's Customer Service ninety (90) days in advance of the desired effective date.

Aspirus Network, Inc. (ANI)
Practice Demographic or Location Change Form

Please complete the Form below:

All fields are required. If it does not apply, please enter N/A. Attach any supporting documentation, including a W-9 if applicable, along with the completed Form. For location changes, please include a list of providers (Excel format preferred) and note whether it is the provider's primary or an additional location.

ANI Members

Member Organization: ☐ **CIN Member** ☐ **Affiliate Member**

Type of Change

☐ Tax ID Number ☐ Legal Name and/or DBA ☐ Ownership ☐ NPI ☐ Physical Address ☐ Billing Address ☐ Phone Number ☐ Fax Number
☐ Other_____

Will the Change Impact:

☐ Inpatient/Outpatient ☐ ASC ☐ Clinic Non-RHC ☐ Clinic RHC ☐ SNF ☐ Home Health/Hospice ☐ FQHC ☐ Psych Inpatient/Outpatient
☐ Comprehensive Inpatient / Outpatient Rehab / BH Mental Health Treatment Program ☐ Non-Licensed or Non- Credentialed Facility
☐ Other_____

For changes to a facility or clinic currently covered under ANI's payor contracts:

- Is this a ☐ Primary Care Clinic or a ☐ Specialty Care Clinic
- Is this an outreach location only? ◯ Yes ◯ No
- Hospital Affiliation? Or what facility does your practice admit patients to?
- Is this site for directory purposes only? ◯ Yes ◯ No
- Is this request the result of a Merger/Acquisition? ◯ Yes ◯ No

Comments:

Has your organization completed the state required licensing, accreditation, and/or re-credentialing for the facility or clinic?

◯ Yes ◯ No. If no, please provide explanation:

Has your organization reached out to ANI's contracted payors to complete facility re-credentialing (i.e., TIN, NPI, FCHQ, RHC, or locations that require licensing or re-credentialing)?

◯ Yes ◯ No. If no, please explain:

Requested effective date of the change:

DO NOT PROCEED UNTIL THE ABOVE IS COMPLETE

Are the following documents included: ☐ W-9 ☐ License ☐ Provider List

Member Organization to Complete	
Old Information	**New Information**
Tax ID Number:	Tax ID Number:
Location NPI:	Location NPI:
Legal Name:	Legal Name:
DBA:	DBA:
Phone Number:	Phone Number:
Fax Number:	Fax Number:
Physical Address	Physical Address:
Physical City:	Physical City:
Physical State:	Physical State:
Physical Zip:	Physical Zip:

Note: Changes must be submitted at least 90 days prior to the effective date.

Please indicate if there are any changes to the general day hours of operation:

Sunday	
Monday	
Tuesday	
Wednesday	
Thursday	
Friday	
Saturday	

MEMBER ORGANIZATION CONTACT AND BILLING INFORMATION	
ONLY complete if a change has occurred to any of the following key contacts for your organization.	
Organization Practice Administrator:	**Additional Location Contact:**
Organization Practice Administrator Email:	**Additional Location Contact Email:**
Clinic/ Facility Site Address:	
City, State, Zip Code:	
County:	
Billing Contact Representative:	**Physician/Medical Director Name:**

Billing Contact Representative Email:	**Physician/Medical Director Email:**
Billing Contact Representative Phone:	**Physician/Medical Director Phone:**
Billing Address:	
Billing City, State, Zip:	**Organization Credentialing Contact:**
Billing County:	**Organization Credentialing Contact Email:**
Billing Phone:	**Organization Credentialing Contact Phone:**
Billing Fax:	**Organization Credentialing Contact Fax:**
Office use only: ANI Contract Type	
Office use only: ANI Class	

Form Completed by: _____ Phone:_____ Date:_____

Email Address:_____

Please Submit this form to: **CustomerService-ANI@aspirus.org

**ANI will review and forward to ANI Credentialing and Provider Enrollment upon approval.

ANI Initials: _____ Date: _____